IV IRON PATIENT ASSISTANCE PROGRAM ENROLLMENT APPLICATION

Requested Product

☐ **INJECTAFER ®**
(ferric carboxymaltose injection)

Patient Information

Patient's Name:

Address (no PO boxes please):

Case Number:

City:

State: Select

Zip Code:

Social Security Number:

Daytime Phone:

Evening Phone:

Sex:

Date of Birth:

Primary Diagnosis:

Secondary Diagnosis:

Is this patient currently receiving dialysis treatment? ○ Yes ○ No

Provider Information

Physician Name:

Address (no PO boxes please):

Contact Person (other than physician):

City:

State: Select

Zip Code:

Facility/Practice Name:

Daytime Phone:

Fax:

Insurance Information

Please provide data on insurers that provide health insurance benefits to this patient:

Insurer	Status	Plan Name	Effective Date
☐ Medicare			
☐ Medicaid			
☐ Private			
☐ Other			

☐ Patient does not have and is not eligible for any public health insurance.

Financial Information

Total annual household income (from most recent federal tax return):
$

Number in Household:

Patient Certification and Consent

I would like to receive Injectafer®, as prescribed by my physician and indicated above, free of charge from Daiichi Sankyo, Inc. a parent company of American Regent, Inc. (AR). I do not have, nor am I eligible for, any private or public health insurance or any other form of assistance with my medical expenses.

I certify that the above information is correct to the best of my knowledge, and agree to notify the program of any changes. I understand that this information will not be used for any other purpose unless I give written consent, unless it is required by the government, or unless AR, and Daiichi Sankyo, Inc. removes my name and any other identifying information.

I understand Daiichi Sankyo, Inc. has the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. I also understand that, although Injectafer® may be given to me without cost now, this does not mean I will be entitled to receive it without cost indefinitely.

Patient Signature **Date**

Provider Certification Statement

I have determined that Injectafer®, as indicated above, is medically appropriate for the above named patient.

I have received the consent of the above named patient to provide this information and to request assistance on his or her behalf.

I agree to allow Daiichi Sankyo, Inc. a parent company of American Regent, Inc. (AR), or an authorized AR representative to review the medical, financial, and insurance records for Program patients at any time for the purpose of verifying the patient's medical, financial and insurance status and I have received the consent of the above named patient to do so.

I understand that AR, and Daiichi Sankyo, Inc. reserves the right to modify or discontinue this Program with respect to any patient, or in its entirety, at any time.

I understand that no third party or patient may be charged for any Injectafer® for which replacement product is sought under this Program.

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the Program of any changes of which I become aware, which could affect the patient's eligibility status.

Provider Signature **Date**

Daiichi Sankyo, Inc. a parent company of American Regent, Inc. (AR) reserves *the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time.* Daiichi Sankyo, Inc. a parent company of American Regent, Inc. (AR) also reserves the right to make an independent determination of medical indigence in all cases.

Please send this completed form to:
Injectafer Patient Assistance Program
PO Box 220342
Charlotte, NC 28222

Phone: 877-448-4766 Fax: 888-354-4856